SHIFTING ATTITUDES TOWARDS SEEKING HELP IN A YOUTH DEVELOPMENT PROGRAM: A PROGRAM EVALUATION

BY

SARAH E. BEALS-ERICKSON, M.A.

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Chairperson Michael C. Roberts, Ph.D.

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Eric M. Vernberg, Ph.D.

_____

Paula J. Fite, Ph.D.

_____

Julianne Boydston, Ph.D.

_____

Christopher M. Johnson, Ph.D.

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The Dissertation Committee for Sarah E. Beals-Erickson, M.A.

certifies that this is the approved version of the following dissertation:

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Chairperson Michael C. Roberts, Ph.D.

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Abstract

Youth development programs often suffer from a dearth of evaluation of the programs' long-term effects. To integrate more comprehensive and impactful evaluation in youth development programs, the present project evaluated how program participation affected caregivers' intentions to seek help for mental health issues in the future. Service utilization, perception of support, and satisfaction with the program were all included as predictors of intentions for seeking help. Using Structural Equation Modeling (SEM), an original model based on the theory of planned behavior was tested. It was found that program participation significantly increased families' willingness to seek help for child mental health issues. When testing the hypothesized mechanisms of this change, mediational models showed that support and satisfaction variables did not explain the increase of help-seeking intentions, contrary to predictions. Implications of these results for youth development programs and for professionals working with children and families in need of services are discussed.

Keywords: youth development programs; help-seeking; service utilization

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Because this has been stated in a dissertation, now the world will know this as a scientific truth, not merely an opinion. I love you all.

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Shifting Attitudes Towards Seeking Help in a Youth Development Program: A Program Evaluation

In the United States many programs exist targeting youth who have been deemed to be "at-risk" for a host of negative behaviors or psychopathology. Historically, youth development programs began as responses to youth crises (e.g., juvenile crime, "poor character"), but over time, programs have sought not only to prevent problems but also to develop positive features in youth (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004). Youth development program missions often include such foci as reducing or preventing HIV-exposure, early sexual activity, or risky sexual behavior (see review by McBride & Bell, 2011). Other programs target use or misuse of drugs and alcohol (e.g., DARE and DARE Plus, Perry et al., 2003). Still other programs seek to decrease participation in community violence (e.g., Rodney, Johnson, & Srivastava, 2005). Prevention of school failure and increased school participation are also common targets of youth development and prevention programs (Catalano et al., 2004). The positive aspects in youth that many programs seek to develop include increasing self-esteem, spirituality, resilience, and generally positive developmental progression from youth to adulthood (Brown & Roberts, 2002; Catalano et al., 2004). Besides programs intended for broad youth audiences, many programs specifically geared for identified groups also exist, such as ethnic minority youth (e.g., Chipungu et al., 2000) or youth living in an urban environment (e.g., Valentine, Gottlieb, Keel, Griffith, & Ruthazer, 1998).

Youth development programs are funded, developed, and conducted through a variety of venues. Faith-based, volunteer-based, and school/city/community-based programs are common (Bruyere, 2010). Youth positive development programs may also be supported through

governmental (Wu & Van Egren, 2010), non-profit (Herrera, Baldwin, Grossman, Kauh, & McMaken, 2011), or private (Holleman, Sundius, & Bruns, 2010) agencies.

Youth development and prevention programs typically have focused on populations that demonstrate multiple biopsychosocial risk factors that put them at risk for developing problematic behaviors in the future or failing to reach their maximal potential competency (Catalano et al., 2004). In other words, youth development and prevention programs pre-emptively target behaviors that the youth involved in the activities in the programs are not yet engaged in. Consequently, these programs are clearly oriented to the future; however, in evaluations of these programs there has been little evidence that evaluators assess if program participation can promote help-seeking in the future should the problems for which the population is at risk actually come to fruition. This gap in future-oriented assessment may come from lack of resources and research know-how (Brown, 2005), or even failure to engage the population in the program at the community level (Lambert & Black, 2001). The present project sought to review program evaluations of these types of programs and identify several new variables important in shifting attitudes towards help-seeking that have not yet been assessed. This project also posits and tests the idea that participation in these youth development programs is important because a positive experience in these programs could make obtaining future services more accessible and acceptable for families.

Program evaluation: Definition and models

Program evaluation can be generally defined as an applied form of research that seeks to assess the effects of a human service program, including the processes and outcomes of such programs (Royse, Thyer, & Padgett, 2010). Royse et al. (2010) noted that there are typically multiple motivations for completing a program evaluation, including, but not limited to: (a)

demonstrating that the program has "worth;" (b) demonstrating that the program accomplishes its objectives; (c) demonstrating that participants are satisfied with the program; and (d) demonstrating needs or areas targeted for improvement within the program. Program evaluation likely also includes assessment of process variables, such as how program organizers engage the community in the program (Berlin, Brooks-Gunn, & Aber, 2001; Lambert & Black, 2001). Other processes assessed may be how programs develop, maintain, and accomplish adherence to goals and strategic visions and collaborate with systems within the community (Betts, Peterson, Marczak, & Richmond, 2001). Program evaluation may take place at multiple points in program development and implementation, including when the program is being formulated, when the program is in progress, after the program is completed, and with long-term follow up to assess indirect as well as direct effects of participation (Roberts & Steele, 2005).

Many models of program evaluation exist with great range in models' complexity. Some program evaluations may focus simply on the immediate outcomes of a program, while others may call for more in-depth conceptualization and measurement (Roberts & Steele, 2005). For example, the Symptoms, Functioning, Consumer perspectives, Environmental contexts, and Systems (SFCES) model involves evaluation not just of participants, but broader assessment of participants' contexts (Hoagwood, Jensen, Petti, & Burns, 1996). Similarly, Wilson and Lawman (2009) recommended an integrative model of biopsychosocial and ecological factors when constructing and evaluating programs for youth and families. Ostrom, Lerner, and Freel (1995) also suggested in their Development-in-Context-Evaluation (DICE) model that qualitative and quantitative assessments be made in order to collaboratively engage communities in running their own programs. Furthermore, Roberts, Brown, and Puddy (2002) outlined a number of categorical variables to be assessed in a comprehensive model of program evaluation of

programs for children and families. For example, a comprehensive program evaluation might include information on: demographics; diagnostic information; program processes; behavioral, psychological, educational, health, and potentially harmful outcomes; cost/benefit analyses; satisfaction; use of other services; broader, indirect effects on societal, legal, or policy considerations; and differences in individual responses to programs (Roberts & Steele, 2005).

While there are examples of successful program analyses using these models, with so many comprehensive and complex models for program evaluation, it is clear that there are frequent possibilities for community organizations to err in program evaluation. Many organizations, especially those conducting programs on restricted budgets, may omit key variables, make errors in their data collection, and struggle to retain participants for follow up. It is furthermore a concern that many programs may not be evaluated at all.

Problems in program evaluation of youth programs

Programs preventing health-compromising behaviors in youth are certainly in line with Applied Developmental Science perspectives that seek to support youth development and prevent problems (Lerner, Wertlieb, & Jacobs, 2005). However, many service-oriented organizations are not necessarily "research-minded," in that they may not make decisions based on empirical data. This may occur for a variety of reasons, including "ideological, political, philosophical, or financial" (Roberts & Steele, 2005, p. 351). Failure to make decisions from data can lead to the development and implementation of programs for youth that sound beneficial but in actuality may have iatrogenic effects (e.g., the original DARE program; Rosenbaum, 1998). Indeed, according to Brown (2005), many programs may only seek to evaluate their effects on participants if the program fails in some way. Per Brown (2005), if the program seemed to run smoothly according to staff and consumer perspectives, then evaluation may be

deemed unnecessary by program staff. This strategy of only assessing a program when it does not reach goals is not only uninformative, but also potentially unethical. Failure to evaluate programs may expose youth to ineffective or potentially harmful programming and may waste the time and resources of participants and funders alike.

Furthermore, participation in youth development programs is often time-limited (e.g., one to several weeks in most of the camp programs reviewed by Brown, 2005) or low intensity (e.g., the DARE Program ran for approximately 17 weeks for only 45 minutes to 1 hour per week; Rosenbaum, 1998). To establish long-range effects, longitudinal studies are the best methodology, but service-oriented agencies may not have the resources or data management expertise to follow participants over more than one data collection point (Roberts & Steele, 2005). Such lack of multiple timepoint assessment could prevent funders and program evaluators from understanding and maximizing their program's ability to produce behavioral or cognitive change in participating youth and families. This may further increase barriers to establishing proper program evaluation methods and infrastructure. These barriers are ultimately problematic because in order to continue to justify support for the use of resources for these programs, agencies need to demonstrate that their programs are effective (Roberts & Steele, 2005). Essentially, if a program is worth implementation, then it is also worth the effort to evaluate it. The present program evaluation addresses this problem by assessing participants at two timepoints (before and after program completion), and seeks to understand future intentions of participants' families to seek services, a rarely assessed area that could be affected by participation in a youth development program.

Program evaluation of pre-/post-intervention changes often have not considered the notion that successful participation in youth development programs may have provided

information and education that could have long-term impact that is not immediately assessed. For example, programs often educate about what supports or services are available should needs arise in the future. Youth who participate in prevention programs (especially those programs that are universal in focus) are not likely to be currently engaged in the behaviors that the programs are trying to prevent. Therefore, it would seem disingenuous to assert the program "worked" merely because at the end of the intervention youth are still not engaging in a behavior that they were not participating in beforehand.

Consequently, another way that program developers and evaluators can define program success is whether program participation leads to shifts in attitudes or intentions to seek help in the future if/when help is needed. A positive experience with a prevention or youth development program may help decrease barriers or stigma for accessing supports for families. Indeed, some research has found that participation in a positive youth development program can have a "cascading" effect on parenting and other youth contexts/relationships that predict better functioning in the future (Lewin-Bizan, Bowers, & Lerner, 2010). Furthermore, Lewin-Bizan et al. (2010) issued a call for more research on understanding the "nuance" of how parents' roles affect outcomes for youth post-youth development program participation. Increases in willingness to seek help may be a part of such "nuance" that the authors spoke of. Additional work has found that parents' psychological symptoms and functioning improved when their children participated in youth programs (Beach et al., 2008; Kogan et al., 2012). Moreover, other research has illustrated that increased family involvement in youth programs may also help families connect with other systems and improve the child's experience in the program. For example, Kreider and Raghupathy (2010) found in their pilot of an afterschool program with family outreach components that parents reported practical and emotional support from the

program, including connections with law enforcement, economic, and school systems within the community. The extant literature illustrates broad positive effects for program participation; however, these data were largely qualitative. Clearly, the research literature supports engaging parents in youth development programs. What has been under-examined with quantitative data is whether the positive effects of parent and youth program participation provides parents with additional sources of support, access to future services, and de-stigmatization of help-seeking. Parents are generally the ones who make decisions about what community services are pursued (Berlin et al., 2001). Consequently, parents who perceive more support are more likely to seek services for their children (Lindsey et al., 2012). Research on service disparities has shown that stigma and negative beliefs about service provision interfere in accessing services (Barksdale, Azur, & Leaf, 2009). Others have also demonstrated that parents may have negative expectations about how effective treatment will be (Richardson, 2001). If youth development program participation yields entry-level experience that is satisfying and positive for family members and youth, this may provide more support to parents for seeking services and may provide an experience that removes the stigma of seeking support. Correspondingly, a significant gap in the literature exists regarding how participation in a youth development program may facilitate willingness towards increasing service utilization. Some may argue that families who are more willing to seek services are more likely to participate in youth development programs. Because this project includes multiple timepoints, more indication about the directionality of these concepts' influence on one another will be explored.

Help-seeking: Willingness to seek services

Help-seeking is generally defined as a process that involves recognizing a problem, and then going to another person (either formally or informally) as a resource for coping (Rickwood,

Deane, Wilson, & Ciarrochi, 2005). Rickwood et al. (2005) conceptualized help-seeking as a multi-step process, including: (a) awareness of problems; (b) expression of symptoms and need for support; (c) availability of sources of help; and (d) willingness to seek out and disclose problems to others. It is this last step, intentions for seeking help, which is most relevant in the present project. In line with the theory of planned behavior (Ajzen & Fishbein, 1980), an individual's cognitive intentions for behavior directly predict his/her engagement in actual behaviors (Wilson & Lawman, 2009).

Rickwood et al. (2005) found, in general, that youths' intentions for seeking help are moderately and positively correlated with engaging in help-seeking behaviors. Furthermore, research has shown for adolescents, factors such as stigma and negative attitudes towards seeking help from professionals can decrease intentions to seek help. Other factors, including positive social influences and positive experiences with services, can increase intentions to seek help (Rickwood et al., 2005). Although information on help-seeking intentions for adolescents has been established, to date, little information is available about how family or caregiver intentions for seeking help are formed. This represents a significant gap in the research literature and overlooks the important factor of the caregiver's role in help-seeking. Youth typically do not refer themselves for formal services, but instead they rely on parents to recognize and seek services (Rickwood, Deane, & Wilson, 2007; Sayal, 2006). Furthermore, modern models of understanding youth development and facilitating healthy behaviors typically emphasize an ecological approach, which includes recognizing the importance of involving youths' larger systems (including their families; Wilson & Lawman, 2009). A first step in filling this gap in the literature is assessing how families' participation in a youth program affects parents' help-seeking intentions, in the context of the families' current use of services.

Service utilization: Reducing deficits and barriers

Historically, it has been documented that many children and families with mental health and/or substance use problems do not receive the services they need (e.g., Knitzer, 1982). Despite many governmental, professional, private, and research efforts to improve and understand service delivery and use, current models have often been deemed inadequate in fully addressing needs (Burnett-Ziegler & Lyons, 2010; Steele & Roberts, 2005). Indeed, service utilization continues to typically be lower than the actual needs for mental health, housing, and financial support children and families have (e.g., Power, Eiraldi, Clarke, Mazzuca, & Krain, 2005).

This underutilization of services is likely due to a number of reasons. Thus far, the literature has focused on assessing several demographic or clinical factors that may affect service utilization in children, youth, and families. Previously examined factors influencing service utilization include gender (Maschi, Perez, & Gibson, 2010), ethnicity (Barksdale et al., 2009), caregiver strain (Brannan, Heflinger, & Foster, 2003), and impairment/symptom severity (Power et al., 2005). Furthermore, research into service utilization may prioritize the use of formal (professional) resources, but it is also likely that youth and families may prefer using more informal resources (e.g., friends, family members, religious communities; Rickwood et al., 2005).

What has yet to be explored within this conundrum of service utilization deficits and barriers is if participation in youth development programs affects families' willingness to seek help or access services after their program experience. Indeed, Power and colleagues (2005) stated that the research literature has yet to identify what factors move families from recognizing there is a problem to actually being willing to seek services. One possibility that has not been

assessed is that service utilization may be increased by opportunities for learning about community or government-based supportive aid programs and how to access them in a minimally-stigmatizing way. Participation in a youth prevention or development program may be such an opportunity. However, families' intentions of seeking future services after their experience with prevention/development programs has not been included in recommended models of program evaluation (Roberts & Steele, 2005).

It seems likely that program participation could be important in shifting attitudes towards help-seeking because staff often provide some support (both instrumental and emotional) to caregivers (Beaulac, Olavarria, & Kristjansson, 2010). As Power et al. (2005) noted in their review, social support from professionals and paraprofessionals (such as the staff at a youth development program) may play a role in moving families towards greater willingness to seek help. With greater support for seeking services, families are more likely to access them for their children (Lindsey et al., 2012). It is also possible that the children and families participating in youth prevention or development programs are already those most amenable to accessing services. However, there is little literature to date to confirm or refute this notion. This suggests a need for more assessment of willingness to seek help.

Among all of the potential variables included in youth program evaluations, the most widespread domain that is generally assessed is child/family satisfaction with the program (Roberts & Steele, 2005). Adding an assessment of help-seeking intentions can better provide importance and context to satisfaction with program participation. Being satisfied with an initial entry into service use may set the stage for later use of services. Assessing these more indirect effects that youth development program participation may have is consistent with theoretical and practical suggestions for improving program evaluation (Berlin et al., 2001; Roberts & Steele,

2005). Additionally, including help seeking intentions, satisfaction, and support variables may provide an effective way that service-oriented agencies can demonstrate short-term program success even if they do not have the resources for long-term follow up data collection. To fill this gap in the literature, the present project will assess pre-existing service utilization and determine if willingness to seek more services is influenced by a family's experience (satisfaction and perception of support) through their participation in a youth development program.

Purpose

The current project evaluates outcomes of a youth prevention/development program by assessing youth and caregiver satisfaction, family support, current service utilization, and caregivers' willingness to seek more help in the future (both before and after program participation).

Hypotheses

The following hypotheses are tested: (a) after program participation, families will indicate higher levels of willingness to seek help than they did prior to participating in the program; (b) satisfaction with program participation, family support, and current level of service utilization will be predictive of willingness to seek help in the future; and (c) satisfaction and family support variables will mediate the relation between current level of services and willingness to seek help.

Methods

Participants

Participants were 124 young adolescents who participated in a prevention/positive youth development program (AileyCamp; see Brown Kirschman, Roberts, Shadlow, & Pelley, 2010) as well as 135 caregivers of these youth. Some families opted for only youth to participate, others

opted for only caregivers to participate, and some opted for both parents and children to participate. Thus, the number of adolescent and caregiver participants did not match exactly. AileyCamp is a six-week summer dance camp program that seeks to prevent substance use, community violence participation, and risky sexual behaviors through psychosocial groups and the provision of positive alternative activities (in this case, dance). The program is provided at no cost to families through a local chapter of a national non-profit organization that seeks to encourage dance and personal development in predominantly African-American communities. Transportation to and from AileyCamp is also provided free-of-charge to families. Participants were typically from economically disadvantaged homes in several mid-sized, urban, Midwestern cities. See Tables 1 and 2 for detailed descriptive statistics of the sample.

Table 1 *Demographic Information of Sample Youth (N =124)*

Characteristic	Percentage of Sample±	Mean	Median	Range
Age (in years)		11.98	12.00	8-21
Gender				
Male	12.6			
Female	87.4			
Ethnic Background				
African-American	86.6			
Hispanic	11.8			
American Indian	10.1			
Caucasian	9.2			
Other	3.4			
Native Hawaiian	0.8			

±Percentages calculated from completed responses only. Demographics missingness: Gender, 17.9% missing; Ethnic Background, across all ethnicities, 17.9% missing

Table 2 *Demographic Information of Sample Caregivers (N =135)*

Characteristic	Percentage of Sample±	Mean	Median	Range
Age (in years)		37.49	35.50	11-67
Gender				
Male	17.9			
Female	82.1			
Ethnic Background				
African-American	80.7			
Other	3.5			
Hispanic	7.9			
American Indian	3.5			
Caucasian	10.5			
Household Yearly Income				
$10,000 or less	26.2			
$10,000-$20,000	15.9			
$20,000-$30,000	19.6			
$30,000-$40,000	15.9			
$40,000-$50,000	11.2			
$50,000-$60,000	3.7			
$60,000 or more	7.5			
Number of People in Household		4.44	4.00	2-8
Service Utilization (Number of Services Used)		3.86	4.00	0-15

±Percentages calculated from completed responses only. Demographics missingness: Gender, 21.4% missing; Ethnic Background, across all ethnicities, 21.4% missing; Income, 26.2% missing; Service Utilization = 21.4% missing.

Measures

Demographics/Service Utilization. To capture current use of services and various demographic variables, caregivers completed a demographic form assessing income, household size, caregiver and child information, as well as current services used/received. To assess ethnic identity, both caregivers and youth were given the option to "select all that apply" as opposed to a forced choice/identification with a particular group or label. This was deemed to be the most culturally sensitive way to assess ethnic identity and is supported by methods used by researchers who are experts in youth ethnic identity and health disparities (Bilheimer & Klein, 2010; Brattar & Heard, 2009). A comprehensive list of both formal and informal services was provided, with the instruction for families to mark all that apply and complete blank spaces to indicate any additional services not listed. Table 3 further illustrates the details of families' service utilization. This measure is included as an appendix.

Table 3 *Services Utilized by Sample*

Benefit or Service	Percentage Using	Benefit or Service	Percentage Using
Social Security	13.1	Clothing/food Services	3.5
Survivor Benefits	1.4	Financial Services	5.3
Food Stamps	32.4	Public Services	11.4
WIC	3.4	Public Transportation	31.6
TANF	3.4	Museums/Attractions	14.0
Child Support	13.8	Movie Theaters	30.7
Faith-based Services	30.7	Newspaper/Radio/Media Services	21.1
Community Center/Org.	7.0	Parks and Recreation Services	31.6
Community Health Clinic	7.9	Neighborhood Support Programs	2.6
Hospital	20.2	Parent Activity Programs	5.3
Mental Health	9.6	Head Start	5.3
Case Management	2.6	Child Care	0.9
Substance Abuse Programs	0.0	School Programs	20.2
Disability Services	2.6	Tutoring	7.0
Housing Support/Assistance	6.1	Mentoring	9.6
Residential Services	0.0	Other±	6.1

±Of those specifying "Other" services, the following were listed: school counselor, speech therapist, PTA, sports teams, Big Brothers/Big Sisters, Boys & Girls Club, Kansas City Friends of Alvin Ailey.

Satisfaction. A brief, 9-item satisfaction questionnaire was administered to both parents and youth at the end of AileyCamp. Items are anchored on a four-point Likert-type scale ranging from 1 ("really false") to 4 ("really true"). The questionnaire was developed with the non-profit agency administering the program. It is included as an appendix in to this document. This measure includes satisfaction with staff, program content, and overall experience. The questionnaire also assesses if caregivers and youth trusted staff, felt understood by staff, and if program goals were met according to the respondents' perspectives. The program staff use results from this measure to report to funders about the camp and consumers' satisfaction. While not standardized, this measure is specific to this camp and its needs, missions, and goals (as has been the case in most other camp satisfaction measures used in program evaluations; see Brown, 2005). Cronbach's alpha indicated good reliability for this measure (α = .998 for parent-report of satisfaction; α = .997 for child-report of satisfaction). Confirmatory factor analysis results indicated that this measure is adequate for capturing general satisfaction with the youth development program (see Table 9).

Sense of Support. The Family Support Scale (FSS; Dunst, Jenkins, & Trivette, 1984; Dunst, Trivette, & Deal, 1988) was administered to caregivers at the beginning and at the end of AileyCamp. This measure is not copyrighted; as such, it is included as an appendix to this document. Authors report adequate reliability for this measure (Cronbach's alpha = .77-.85). For the current sample, Cronbach's alpha was high (α = .992 for Time 1; α = .995 for Time 2). This 18-item measure asks from where and how much caregivers receive support across a number of sources (family, community organizations, etc.). Respondents rank on a Likert-scale anchored from 1 ("not at all helpful") to 5 ("always helpful"). An additional item was added to this measure to directly assess how the helpful caregivers perceived AileyCamp staff.

Help-Seeking. To capture caregivers' help-seeking intentions, the General Help-Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi, & Rickwood, 2005) was used. This measure is not copyrighted; as such, it is included as an appendix in to this document. The GHSQ is an adaptable, matrix-style measure that assesses how likely it is that respondents would seek help from various sources (including both informal and formal sources) for several different problems. Respondents indicate on a Likert-scale ranging from 1 ("extremely unlikely") to 7 ("extremely likely") for each source listed in the matrix. This measure also includes options of "other" for participants to indicate any additional sources of support and "none" for participants to indicate that they would not seek help from any source to cope with the potential problem. The GHSQ has demonstrated adequate internal reliability (Cronbach's alpha = .83-.85) (Wilson et al., 2005). For the current sample, Cronbach's alpha was high (α = .990 for Time 1; α = .995 for Time 2). The authors of the measure have also demonstrated construct validity as intentions indicated on the GHSQ have been found to be related to later actual help-seeking behaviors (Wilson et al., 2005). The authors recommend that the problem questions and the sources listed be adapted for the specific population used. Consequently, several sources and the question stems were adapted for use with AileyCamp families. For example, the original problem of seeking help for a "personal/emotional" problem was included, but additionally one about youth having a "behavior/drug use" problem was added, because these are areas that AileyCamp seeks to intervene in with skill development. Additionally, two problem questions assessed where parents would turn for their child's problem, and a final problem question asked where parents would turn themselves. This measure was adapted from the original measure to ask caregivers rather than youth themselves about help-seeking intentions. Finally, a "phone/helpline" resource was substituted with "professional agencies" because of greater relevance to youth/families

served by AileyCamp. To assess change over time in this variable, the GHSQ was administered prior to beginning camp and at the completion of camp.

Procedure

Prior to collecting data, Institutional Review Board approval was obtained. Caregivers were provided with consent and study information during parent-orientation nights held by the non-profit agency facilitating AileyCamp. Camp directors explained camp participation, and research team members explained the purpose of collecting program evaluation data. Consent was reviewed verbally, and caregivers interested in participating signed written informed consent documentation. Caregivers then completed a battery of measures (including those described above). Caregivers also completed a second timepoint of data collection at the end of the camp experience. Caregivers were provided with an opportunity to complete time 2 measures before and after the campers' final performance at a performing arts center. Families who could not make parent orientation nights or the final performance were also given the opportunity to complete the packet of measures individually at the non-profit agency within one week of data collection nights. Families obtained a free copy of a DVD of the youths' final performance as an incentive for participation in the program evaluation, sent via mail by the non-profit agency staff.

Youth were assessed in small groups during the first and final weeks of camp participation during their psychosocial skill building and prevention class. All measures were read aloud to youth after obtaining verbal assent.

Because the present project is a part of a larger program evaluation that takes place yearly, it is important to specify that other theses, dissertations, and posters may use other pieces of data from the larger project, and that every year AileyCamp staff present overviews of data collected to their funders to help staff better understand and support their target audience.

However, in accordance with ethics discouraging "piecemeal publication" (Drotar, 2010), this project is necessarily independent of other projects because it is testing several specific hypotheses about help-seeking not used in other projects.

Results

Data Analysis Plan

Initial analyses were completed in IBM SPSS 20 (IBM Corp., 2011), including descriptive information on the sample and variables of interest (means, standard deviations, medians of age, income, etc.). A repeated measures *t*-test comparing pre-/post-program participation scores of willingness to seek help was also conducted to address Hypothesis 1. Additionally, to address Hypothesis 2 next, multiple regressions were conducted with values for Time 1 help-seeking, satisfaction, support, and current service utilization entered individually and in the same step. Finally, to assess the mediational models presented for Hypothesis 3, Structural Equation Modeling (SEM) and bootstrapping techniques were used in Mplus (Muthén & Muthén, 1998-2012), along with Selig and Preacher's (2008) web-based tools for testing indirect effects.

Descriptive analyses

Descriptive analyses of the sample and key variables were completed first (see Tables 1, 2, 3, and 4) using IMB SPSS Statistics 20. As is common in community-based research, analyses showed that a number of data were missing or incomplete (see Table 5). Additional descriptive and mean comparison analyses were completed to examine differences between those who completed both Time 1 and Time 2 data collection and those who only completed Time 1 (see Table 6). There were no statistical differences between these two groups on either demographic variables or Time 1 model variables. Correlational analyses associating the level of missingness

with target variables revealed only one significant correlation. A coded variable indicating the number of key variables missing at Time 2 was significantly and positively related to perceived family support at Time 2 (r = .500, p = .015). This suggests that there may have been missingness not at random for the family support variable at the second timepoint. To manage this missingness, Mplus's Full Information Maximum Likelihood (FIML) procedure was used in all mediational analyses, and multiple imputation was used in SPSS for analyses of Hypotheses 1 and 2. The FIML process is a way on analyzing data with missingness by incorporating all available information (even if cases or variables are incomplete) into the statistical model to form the best possible estimation of the model (Enders, 2012). Multiple imputation is another technique for managing missingness in data in which multiple new datasets are created from the original data with estimated values inserted into missing/incomplete data points (Enders, 2012). Analyses are then completed iteratively with these new data sets, and all estimations are pooled (Enders, 2012). Many researchers report these methods (and imputation in general) as the ideal way to manage missing data (Enders, 2012; Fox-Wasylyshyn & El-Masri, 2005; Schafer, 1999).

Table 4 *Key Variable Means, Standard Deviations, and Medians*

Variable	Mean	Standard Deviation	Median
Parent Satisfaction	3.59	0.32	3.56
Camper Satisfaction	3.17	0.42	3.22
Service Utilization (mean)	0.12	0.08	0.12
Service Utilization (total)	3.86	2.78	4.00
Help-Seeking Time 1	4.47	1.16	4.69
Help-Seeking Time 2	4.74	1.22	4.94
Family Support Time 1	1.71	0.82	1.60
Family Support Time 2	2.34	1.09	2.30

Table 5 *Frequency of Missingness in Key Variables Prior to Imputation*

Variable	Percentage of Sample Missing	N Complete
Parent Satisfaction	37.2	91
Camper Satisfaction	42.8	83
Service Utilization (mean)	21.4	114
Service Utilization (total)	21.4	114
Help-Seeking Time 1	73.8	38
Help-Seeking Time 2	65.5	50
Family Support Time 1	89.7	15
Family Support Time 2	84.1	23

Table 6 *Differences Between Time 1 Only and Time 1/Time 2 Completers*

Variable	Time 1 Only (*M*)	Time1/Time 2 (*M*)	*t*	*df*	*p*
Service Utilization (mean)	.11	.12	.784	114	.435
Help-Seeking Time 1	4.40	4.50	.228	36	.821
Family Support Time 1	1.93	1.68	.388	13	.704
Parent Age	38.25	37.24	.454	110	.651
Household Income±	2.85	3.20	.845	105	.400
Parent Education±	3.15	3.51	.129	105	.897

±Ordinal scales. For Income, 2 = $10,000-$20,000 annually; 3 =$20,000-$30,000 annually; and 4 = $30,000-$40,000 annually. For Education, 3 = Trade School/Community College; 4 = Some college.

Hypothesis 1: Help-Seeking Intentions Will Increase

T-test results for Hypothesis 1 indicated that there was a significant increase in parents' reported help-seeking intentions from before the intervention to after the intervention, but only related to seeking help for their child's "personal/emotional" problem (see Table 7). This partially supported the prediction made for Hypothesis 1 that help-seeking intentions would increase after experiencing the youth development program. It should be noted that for each of the other pre-/post- comparisons, the results indicated that while not achieving statistical significance, means were higher at the end of the program than at the beginning for all portions of this measure.

Table 7 *Repeated Measures T-Test Results*

Variable	*t*	*df*	*p* value
Help-Seeking: CPE*	-2.054	167	.042┼
Help-Seeking: CBD*	-1.157	131	.249
Help-Seeking: PPE*	-1.096	127	.275
Help-Seeking: Total*	-1.806	169	.073

**CPE = Help-seeking for child's personal/emotional problem; CBD = Help-seeking for child's behavior/drug problem; PPE = Help-seeking for parent's personal/emotional problem; Total = Summed total mean across all 3 questions. ┼ = statistically significant at p < .05 level*

Hypothesis 2: Predictors of Help-Seeking Intentions at Time 2

To further assess the relations between key variables, Pearson's *r* correlations were analyzed. Table 8 illustrates these relations. Additionally, multiple regression was used to test Hypothesis 2 regarding significant predictors of help-seeking intentions at Time 2 (after AileyCamp experience). Mean totals or summary scores for each predictor variable were used in analyses. These data were analyzed in several ways. First, Mplus was used to model the simple

regression effect of each potential predictor in its own model. Results indicated some significant prediction. Specifically, help-seeking intentions at Time 1 (B = .755, $SE\ B$ = .128, p <.001, β = .819, R^2 = .671); family support at Time 1 (B = .576, $SE\ B$ = .264, p = .029, β = .550, R^2 = .302); and family support at Time 2 (B = .506, $SE\ B$ = .207, p = .015, β = .499, R^2 = .249) were significant predictors of help-seeking intentions at Time 2. Then, in order to model comparative effects of significant predictors, all potential predictors were included in the regression model; however, this model would not converge. This failure to converge indicates that the model was not able, despite iterative processing, to match the data available. Next, when only the previously identified significant predictors were entered at the same step into a combined model, only help-seeking intentions at Time 1 remained a significant predictor of help-seeking intentions at Time 2 (B = .494, $SE\ B$ = .183, p = .007, β = .716, R^2 = .761). Because only some of the expected predictors of help-seeking intentions were significant, additional analyses were conducted in SPSS in order to determine if using imputed data improved the significance of the expected predictors. However, the pooled estimates for a model with all predictors entered into the same step yielded no significant individual predictors, although help-seeking intentions at Time 1 were approaching significance (p = .081) as a predictor of help-seeking intentions at Time 2.

Table 8 *Correlations Between Key Variables*

Variable	1	2	3	4	5	6
1. Help-Seeking Time 1	—					
2. Help-Seeking Time 2	.291*	—				
3. Family Support Time 1	.427	.123	—			
4. Family Support Time 2	.203	.299	.585	—		
5. Parent Satisfaction	-.056	-.051	.066	-.089	—	
6. Child Satisfaction	.013	-.042	-.072	-.011	.111	—
7. Service Utilization	.126	.189	.274	-.074	.081	-.073

**= p<.05*

Hypothesis 3: Help-Seeking Mediational Models

Mplus was used to conduct structural equation modeling (SEM) to assess for mediational effects of satisfaction and support variables on help-seeking intentions. To assess these effects, several different models were tested. In all models, demographic variables (child's age, gender, and ethnicity) were entered into the model as covariates to control for their effect on outcomes. Items for the variables of interest (child satisfaction; parent satisfaction; family support; help-seeking intentions; and service utilization) were parceled. Parceling variables decreases the number of estimates needed to be made in the model, which in turn increases the likelihood of better estimation. This is a practice consistent with recommendations for SEM analyses (Little, Rhemtulla, Gibson, & Schoemann, 2013). The satisfaction (both parent and child) variables were parceled according to 3 factors: (a) health and skills gained (4 items); (b) positive relationships experienced (3 items); and (c) general reflection of program experience (2 items). The Family Support Scale items were parceled according to factor structure previously reported in the

literature (Taylor, Crowley, & White, 1993), which included 4 factors based on the source of support: (a) familial; (b) spousal; (c) social; and (d) professional. The General Help-Seeking Questionnaire was parceled according to 3 factors related to the nature of the problem for which families might seek help. These factors were: (a) child's personal or emotional problem; (b) child's behavior or drug use problem; and (c) parent's personal or emotional problem. The service utilization variable was initially parceled into 4 factors related to type of service: (a) government benefits (6 items); (b) health and education services (7 items); (c) basic needs services (7 items); and (d) extracurricular or recreational services (9 items). Confirmatory factor analyses indicated appropriate loadings for all of these parcels (see Table 9); however, when using service utilization in analyses, the government benefits parcel had poor standardized loading and was the only non-significant parcel of the 4 parcels. Therefore, models were analyzed with and without the first parcel, but results are reported without the poorly-loading government benefits parcel. Dropping the government benefits parcel from the latent variable of service utilization yielded slightly improved model fit. Furthermore, in all three models, Selig and Preacher's (2008) web-based bootstrapping tool for calculating indirect effects of mediation based on confidence intervals of sampling distributions was used to assess for mediation based on the parameter estimates of the mediational model paths and their respective standard errors (*SE*).

Table 9. *Confirmatory Factor Analysis Model Fit Statistics (N = 142)*

Model	χ^2	RMSEA	CFI
Complete model	χ^2 (210) = 444.67	0.09 (.08-.10)	.73
With SUPP2/HELP2 *r* set at zero	χ^2 (211) = 444.96	0.09 (.08-.10)	.73
With SUPP2/HELP2 and SUPP2/SUPP1 *r* set at zero	χ^2 (212) = 478.43	0.09 (.08-.11)	.69

Latent variables Parcels	Estimate±	*SE*	Standardized Estimate	Standardized *SE*
Help Seeking Time 1				
Child Personal/Emotional	1.18	.14	.91	.04
Child Drug/Behavior	1.18	.16	.84	.05
Parent Personal/Emotional	1.29	.14	.95	.03
Help Seeking Time 2				
Child Personal/Emotional	1.15	.13	.93	.02
Child Drug/Behavior	1.30	.13	.96	.02
Parent Personal/Emotional	1.33	.14	.94	.02
Service Utilization				
Government Benefits*	—	—	—	—
Health/Education	.07	.02	.51	.10
Basic	.06	.01	.63	.10
Recreation	.13	.02		
Child Satisfaction				
Health/Skills	.18	.05	.37	.09
Relationships**	.57	.04	1.00	.00
General	.14	.07	.23	.10
Parent Satisfaction				
Health/Skills	.29	.05	.65	.09
Relationships	.40	.05	.95	.08
General	.19	.03	.60	.08
Family Support Time 1				
Familial	.50	.12	.42	.09
Spousal	.69	.17	.41	.09
Social	1.01	.12	.81	.06
Professional	1.08	.13	.79	.06
Family Support Time 2				
Familial	.58	.13	.48	.09
Spousal	1.00	.19	.56	.08
Social	1.04	.11	.86	.05
Professional	.82	.12	.68	.07

*p < .01 for all estimates; ±Estimates shown for best fitting CFA model; *dropped due to poor loading; **residual set to zero*.

The first model tested sought to examine the degree to which child satisfaction with the youth development program (Time 2 data, collected at program completion) mediated the relation between current service utilization (Time 1 data, collected at beginning of program) and willingness to seek help at the end of the AileyCamp experience (Time 2). For this model, see Figure 1. Results for this first model suggested that although there was adequate model fit, child satisfaction was not a significant predictor of help seeking intentions (Overall: χ^2 (75) = 128.63, RMSEA = .08 (90% Confidence Interval = .06 -.10), CFI = .85, TLI = .79; Indirect effects estimate = -.03, p = .69). Figure 1 details results from Selig and Preacher's (2008) web-based calculation tool. This figure (as well as Figures 4 and 6) provides a graphic representation of a Monte Carlo simulation that produces a 95% confidence interval based on a process similar to bootstrapping in which 20,000 iterations are drawn from the distribution of the parameters for mediation that are estimated by the tested model and available data (Preacher & Selig, 2012). Figure 2 shows that the sampling distribution of indirect effects contains zero (Confidence Interval = -.21 - .12). Consistent with recommendations related to using Monte Carlo simulation to construct confidence intervals when assessing indirect effects (Preacher & Hayes, 2004; Preacher & Hayes, 2008; Preacher & Selig, 2012) this indicates that no significant mediation has occurred in this model.

Figure 1. *Diagram of Model with Child Satisfaction as Mediator*

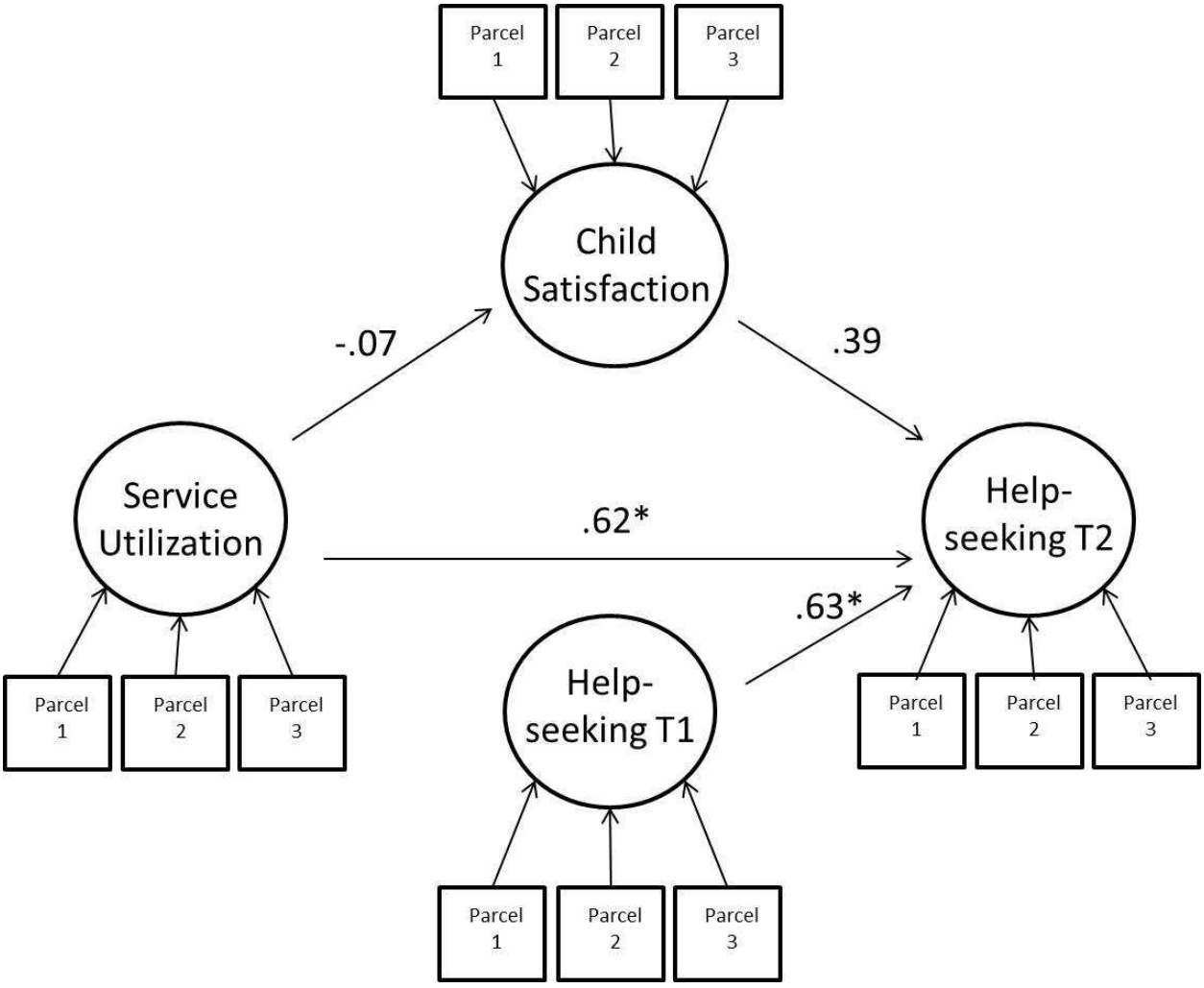
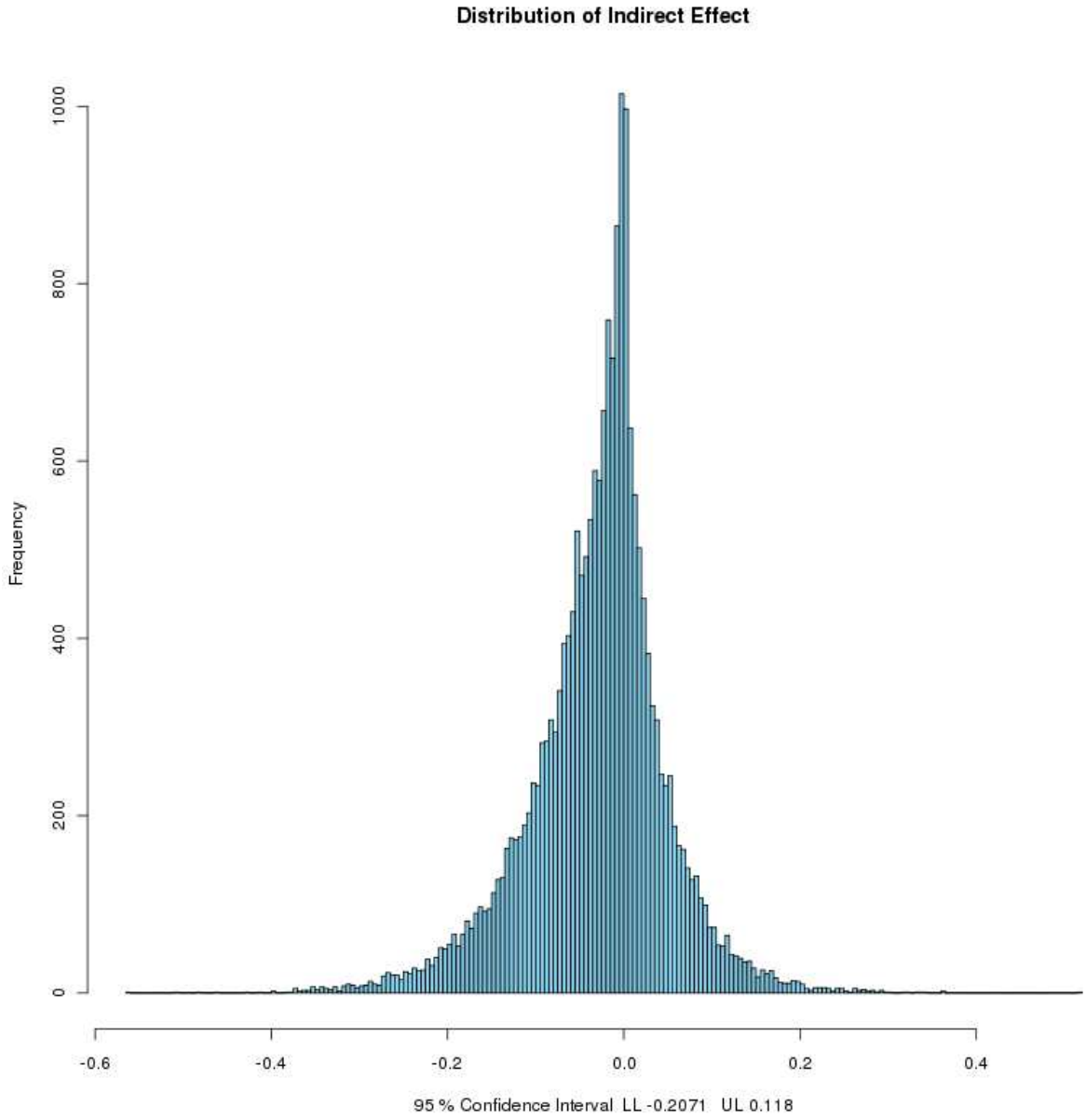


Figure 2. *Monte Carlo Simulation with Child Satisfaction as Mediator*



An additional model (see Figure 3) was tested with parent satisfaction after the AileyCamp program (Time 2 data) as a potential mediator of the relation between current service utilization (Time 1 data) and willingness to seek help in the future after the AileyCamp experience (Time 2 data). Similar to the results for child satisfaction, this second model had good model fit, but did not yield significant mediation from parent satisfaction (Overall: χ^2 (74) = 93.03, RMSEA = .05 (90% Confidence Interval = .00 -.08), CFI = .95, TLI = .92; Indirect effects estimate = -.02, p = .70). Figure 4 details results from Selig and Preacher's (2008) web-based calculation tool. Figure 4 shows that the sampling distribution of indirect effects contains zero (Confidence Interval = -.15 - .08; Preacher & Selig, 2012), which indicates that no significant mediation has occurred in this model.

Figure 3. *Diagram of Model with Parent Satisfaction as Mediator*

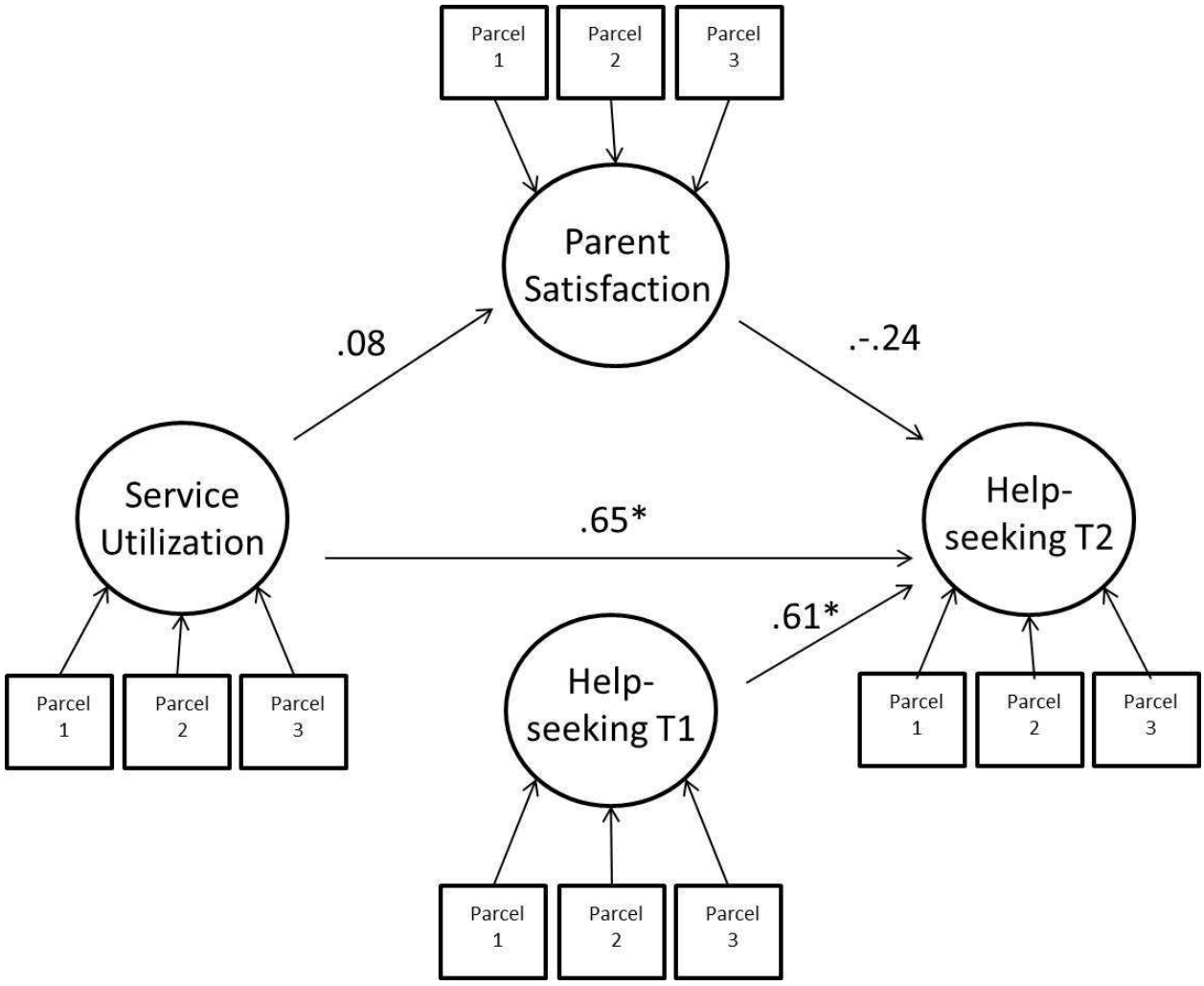
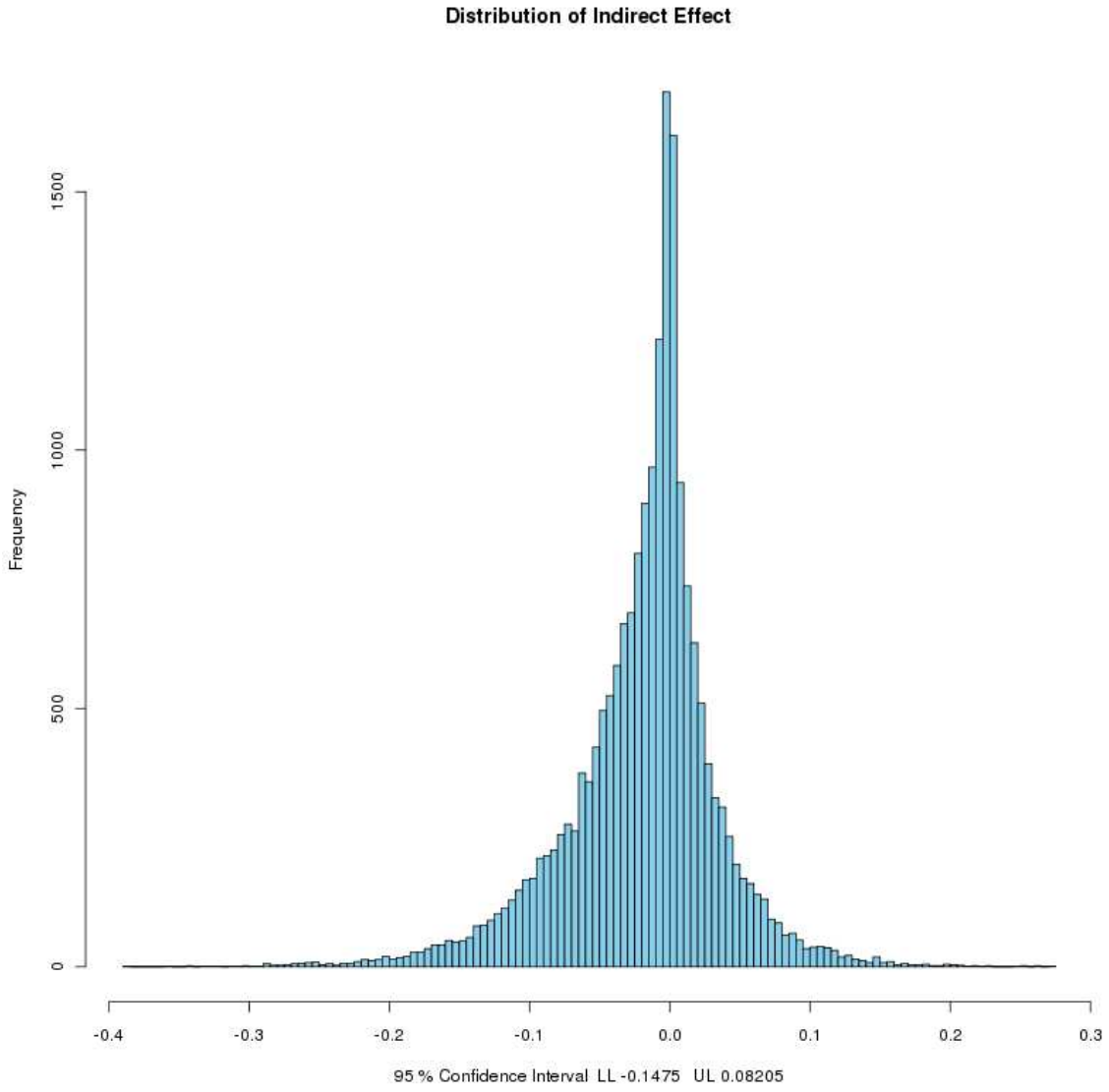


Figure 4. *Monte Carlo Simulation with Parent Satisfaction as Mediator*



A final model (see Figure 5) was conducted to assess the longitudinal effects of perceived support provided to participating families (assessed at both Time 1 and Time 2) as mediators of the relation between current service utilization (assessed at Time 1) and help-seeking intentions (assessed at both Time 1 and Time 2). For this model, both Time 1 and Time 2 data for help-seeking intentions and family support were used to capture the effects of change over time. Using data from both timepoints also allows the model to control for the effect of initial levels of support and help-seeking intentions in the end of camp outcomes. For this particular model, a parcel of the service utilization construct (government benefits) was dropped from the latent construct of service utilization because of poor standardized loading and improved model fit without this parcel. Additionally in order for this model to converge, the residual correlation between family perceived support at Time 2 and help-seeking intentions at Time 2 had to be set to 0 because these variables' residual correlations were initially spuriously correlated to a degree greater than one. Results indicated that model fit was generally poor (Overall: χ^2 (148) = 473.82, RMSEA = .14 (90% Confidence Interval = .13 -.15), CFI = .58, TLI = .46). Additionally, results for indirect effects illustrated that family support at neither Time 1 nor Time 2 was a significant mediator in the model. Figure 6 details results from Selig and Preacher's (2008) web-based calculation tool. Because the sampling distribution of indirect effects contains zero (Confidence Interval = -.04 - .28; Preacher & Selig, 2012), this indicates that no significant mediation has occurred in this model.

Figure 5. *Diagram of Model with Family Support as Mediator*

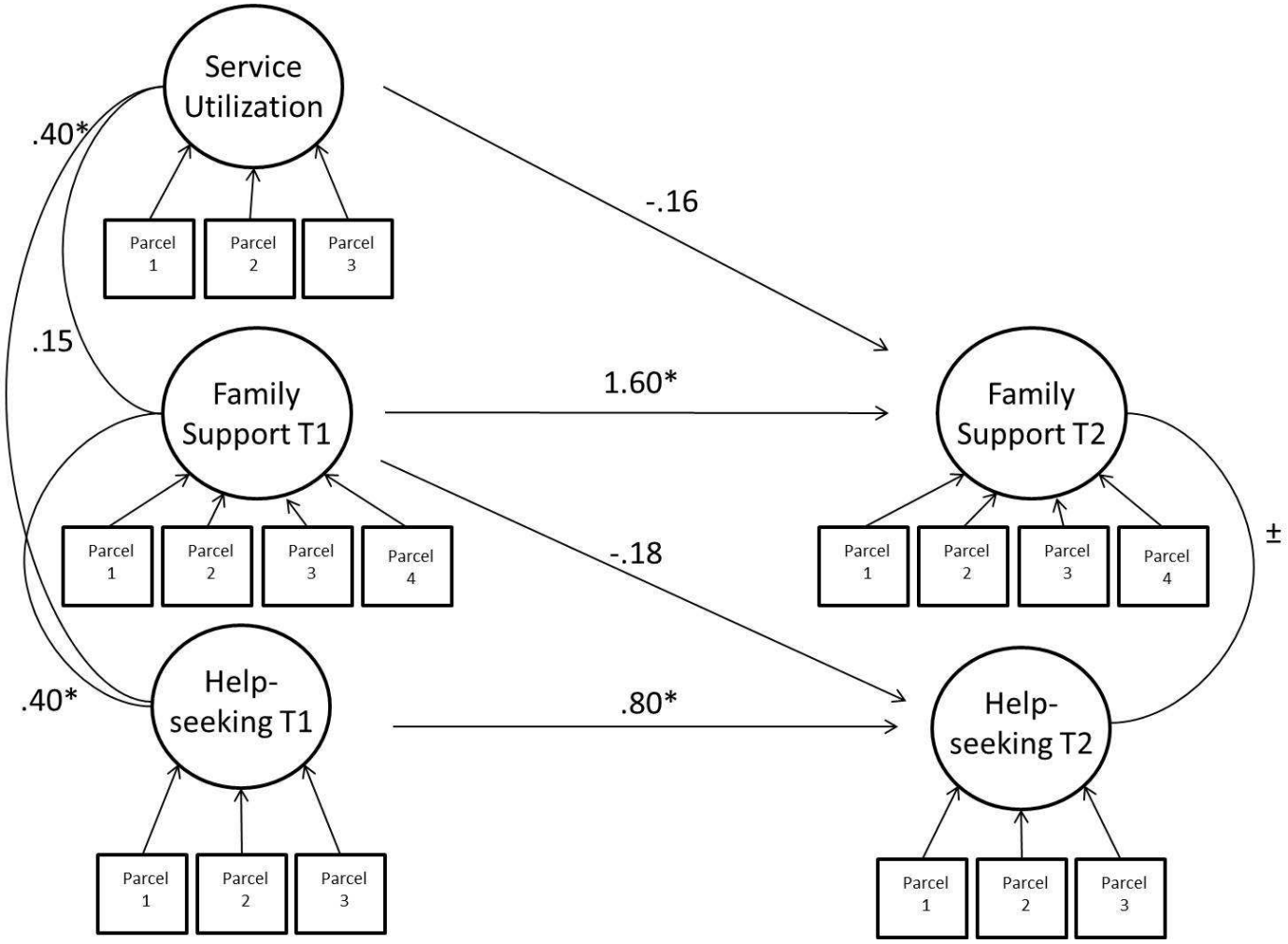
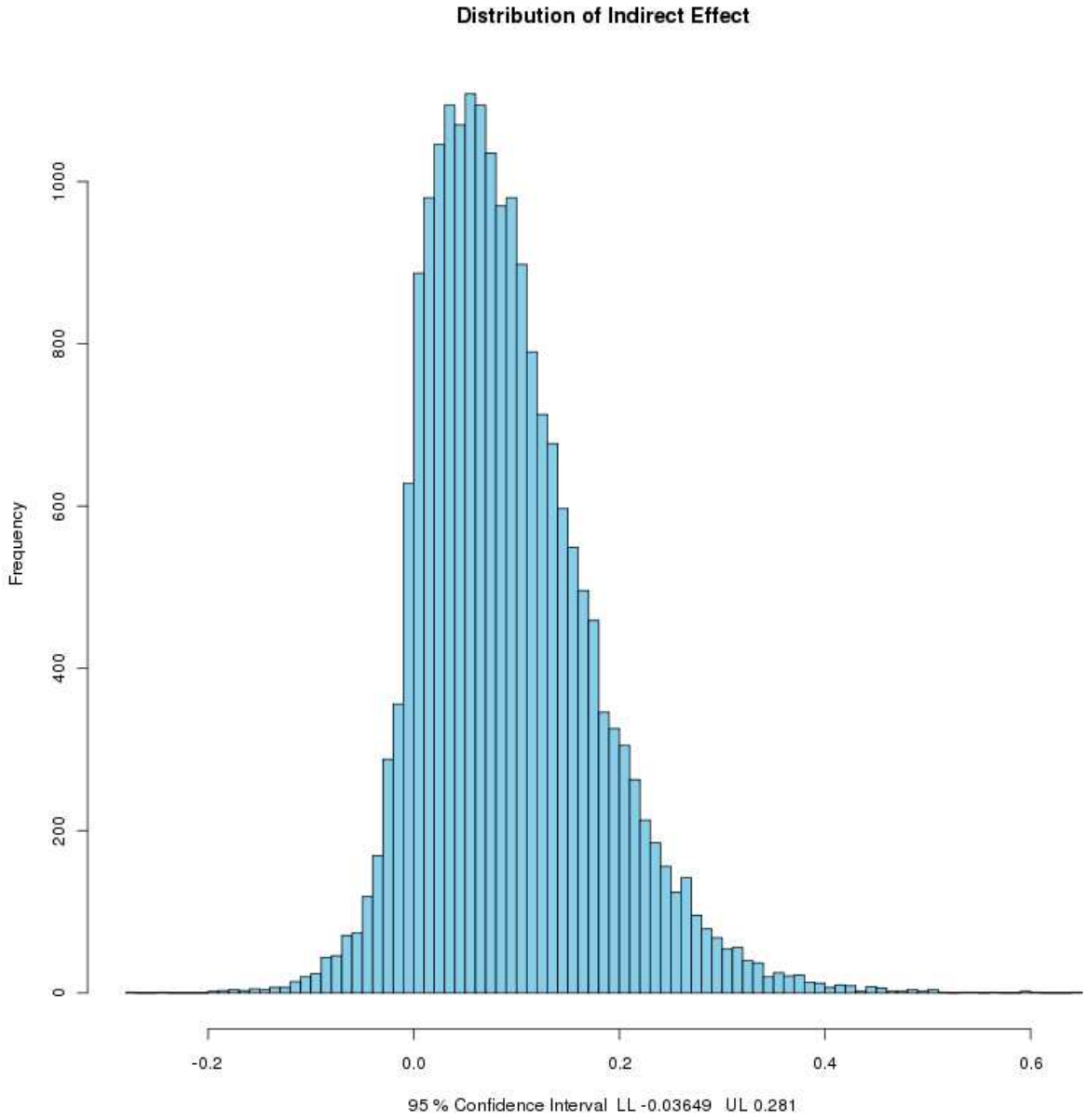


Figure 6. *Monte Carlo Simulation with Family Support as Mediator*



Discussion

This study sought to better understand the processes through which prevention and positive youth development programs affect families in the long-term. Results of this investigation yielded interesting results about the effects of program participation on families' willingness to seek mental health help in the future, within the context of how many services families were already willing to obtain. The results supported some hypotheses, but not all.

First, results showed that willingness to seek help for child participants' personal or emotional problems was significantly greater after participation in a youth development program. Results did not show statistically significant changes in willingness to seek help for either children's behavior/drug problems or parents' personal/emotional problems. These findings partially supported the prediction that participating in a youth development program would increase help-seeking intentions. Emerging research supports the notion than an introductory experience that informs participants about access, expectations, and helpfulness of psychosocial support can increase intentions to seek help in the future (Wilson, Deane, Marshal, & Dalley, 2008).

It seems important to note as well that the results also showed that service utilization at the beginning of camp was generally low, which is consistent with extant literature that urban, low-income, and ethnic-minority populations historically demonstrate low levels of engagement in mental health services (Doornbos, Zandee, DeGroot, & Maagd-Rodriguez, 2013; Lindsey, Chambers, Pohle, Beall, & Lucksted, 2013). For these reasons, increasing willingness to seek help in a population that only minimally uses available supportive services suggests a greater impact of the AileyCamp program than what would have been obtained with a population that already seeks out services for support. Such findings support the belief that the program

developers are reaching their target population (e.g., families that do not already have access to and frequently use services). The families in this study represent the population for whom many researchers and clinicians wish to increase service utilization. They demonstrated increases in willingness to seek help after an introductory community program. Thus, this study illustrates that community programming with psychosocial interventions can be effective in increasing intentions for engagement in available services in the future. Continuing to offer and evaluate similar programs may elucidate important long-term effects on reducing barriers or perceptions that interfere with service utilization (Barksdale et al., 2009).

Second, related to hypothesis 2, initial help-seeking intentions prior to the camp experience were predictive of families' intentions to seek help in the future. However, several of the other factors initially believed to be predictive of willingness to seek help were not significant predictors (e.g., satisfaction with program participation and current level of service utilization). In addition, one expected predictor was significant (e.g., perceived family support, both pre- and post-camp) only when assessed individually. Only initial help-seeking intentions remained significant when all predictors were integrated into one model. Therefore, hypothesis 2 was only minimally supported. These results suggest that, although willingness to seek help increases through participation in a youth development program, it was not clear what variables increased help-seeking intentions other than families' initial help-seeking intentions. None of the expected mechanistic variables affected this change. Although likely still important variables, parent and child satisfaction and pre-existing service utilization were not directly influential in changing families' help-seeking intentions, despite indications from the literature that such factors may play a causal role. While such results equate problems for the proposed model in this study, they do suggest excellent fodder for continued research. The evidence from this study

suggests that some variable is responsible for changing families' perspectives on willingness to seek help, just not one that was directly assessed or conceptualized at present. Such information provides feedback about what will be important for community organizations to select for assessment in program evaluation when prioritizing among the many models and variables suggested (e.g., Hoagwood et al., 1996; Ostrom et al., 1995; Roberts et al., 2002). Instead of focusing on how satisfied families and youth are with a program, assessing what they feel they have gained or what they feel has changed for them may help better understand causal effects for increasing help-seeking intentions. Furthermore, instead of assuming current service utilization will explain future use, querying families regarding what specific situations, problems, or concerns would alter their expectations and willingness to seek help may help community program developers and researchers better understand causal factors at play.

Third, and related to the poor relations of predictors to the dependent variable of help-seeking intentions, no mediational effects for child satisfaction, parent satisfaction, or family perceived support were established. Thus, no support for hypothesis 3 was obtained, despite use of best practice data analysis techniques. It seems, similar with previous research (Lewin-Bizan et al., 2010; Power et al., 2005), that it is challenging to ascertain exactly which features of youth development programs are most responsible for increasing intentions to seek help.

With the results of each hypothesis considered in tandem, this project showed that youth development programs certainly can be a venue for affecting change in families' willingness to seek mental/behavioral health support. What is not immediately clear is what specific factors of the experience are directly responsible for this increase. Satisfaction with the camp experience, current service utilization, and perceived support seemed to be strong contenders for explaining how an initial psychosocial intervention experience could increase interest in accessing needed

services. However, there appeared to be some other aspects of the youth development program experience that may better explain how such programs can affect long-term change.

Influences on help-seeking intentions

One possible factor not assessed in this project is that this program may have reduced perceived stigma for accessing mental health support. Stigma for seeking services for children's mental health issues is well-documented as a significant barrier to help-seeking (Mukolo, Heflinger, & Wallston, 2010). Stigma, shame, and embarrassment prevent not only adult caregivers, who may report shame related to their association with a child with mental health challenges (Mukolo et al., 2010), but also adolescents from developing help-seeking intentions (Yap, Reavley, & Jorm, 2013). While service utilization and intentions to seek help served as indicators of current and future involvement in supportive services, no variables captured families' perceptions regarding the acceptability of seeking help for mental health issues. With this study's population, participants' initial level of stigma or discomfort specifically related to psychosocial interventions is unknown.

It is also unknown to what degree these families were already involved in mental health services. Data showed that only 9.6% of the families endorsed using mental health services at the beginning of camp. It is not known how much contact (e.g., frequency, intensity) with mental health services any of the families had. This notion of degree of involvement may reflect an important and variable difference, as there is a significant "dose" difference between weekly outpatient therapy and meeting once with a school social worker or guidance counselor for a transient issue. As mentioned, the literature suggests that there is often significant stigma attached to seeking mental health services, particularly in urban, under-resourced, African-American youth and caregivers (Lindsey et al., 2013) (e.g., in populations similar to the one in

this study). If psychosocial intervention experiences are positive and normalize the process of seeking help when needed, this defeat of stigmatizing beliefs about seeking services may play a role in facilitating the increase in help-seeking intentions. It is possible that for families with minimal depth of previous mental health experience that this camp experience was more predictive of their willingness to seek help in the future than it was for those with significant depth of psychosocial support experiences prior to AileyCamp. Indeed, Lindsey et al. (2013) noted that in their study population, African-American youth and caregivers reported positive attitudes towards seeking mental health services, but negative expectancies regarding the efficacy of interventions or the discomfort of accessing of mental health services. By providing a high-satisfaction experience with psychosocial interventions as AileyCamp did, negative expectancies about mental health service experiences may be challenged.

In addition to decreasing negative beliefs and expectancies related to seeking mental health services, the increase in willingness to seek help may have been affected by some other aspects of the AileyCamp intervention. For example, mistrust of professionals who provide mental health services has been previously identified as hindering service utilization in low-income, urban, and ethnically-diverse communities (Doornbos et al., 2013). The AileyCamp program targeted this barrier well by specifically seeking to build trusting and supportive relationships between campers and counselors and between caregivers and program staff.

Additional barriers to seeking mental health services include issues specifically relevant to ethnic minority groups, such as fear of culturally-inappropriate care (Knifton, 2012). Existing research indicates that ethnic minority families may feel impeded in seeking services due to a belief that professionals will under-value or misunderstand their culture, and thus push systems of belief that are inconsistent with families' conceptualization of mental illness (Mayberry &

Heflinger, 2013). The AileyCamp program also made efforts to address this potential barrier as well, as the programming was structured to provide a healthy, strengths-based ethnic identity development curriculum. An experience with a culturally-sensitive intervention may have also accounted for increases in intentions to seek help in the future by helping families to feel more confident that providers who respect and value families' individual cultures exist.

Although the results did not support child or parent satisfaction as significant mediators, it should be noted that satisfaction was assessed generally in this study as related to the entire camp experience, which included not just psychosocial skill development, but also exercise and health behavior foci. It is possible that some of the families were more satisfied with one component than the other. It is also possible that some families viewed this program not as a mental health intervention, but instead as a physical activity or recreational activity. Nonetheless, emerging literature suggests that positive youth development programs, even ones that predominantly focus on a physical activity component, also significantly promote psychosocial well-being (Lubans, Plotnikoff, & Lubans, 2012; Ullrich-French & McDonough, 2013). Even if families did not view such interventions as being supportive of both mind and body health simultaneously, such programs still could have been facilitative of positive mental health. What is still little understood about such programs is how families view the predominant focus of physical-activity based youth development programs, and what goals they perceive at the outset of the program. In the AileyCamp program, families were told about the psychosocial aspects of this intervention (e.g., there will be daily groups related to conflict resolution, self-esteem, drug abuse education, sex education). The AileyCamp staff also actively seek to facilitate entry into mental health services for participating youth and families by hosting community resource fairs to connect families with services. They also have counselors on staff to speak with children

individually. However, because this program offers additional components outside of the psychosocial intervention (e.g., supervised structure throughout the summer; physical activity; social interaction opportunities), it is possible that families may be more focused on these other benefits. Future assessment of this program in particular would do well to have families rank the value and importance of these different features. Doing so may help researchers better understand how motivating the psychosocial component of this program is for families at the beginning and at the end of camp. Furthermore, assessment of these variables in other community youth development programs may be more informative about how program participation increases willingness to seek help in the future.

The AileyCamp program's effect on increasing intentions to seek help may have also been due to a number of variables worthy of additional assessment that are congruent with the theory of planned behavior (Ajzen, 2002; Ajzen & Fishbein, 1980). The theory of planned behavior suggests that beliefs about outcomes of a behavior, beliefs about normative expectations for a behavior, and beliefs about the ability to engage in a particular behavior are all significant predictors of behavioral intention. According to the theory of planned behavior, cognitive intentions about completing behaviors immediately precede actual engagement in a particular behavior. The AileyCamp experience provided a positive experience with psychosocial interventions, shared knowledge about available mental health resources in the community, and normalized the occurrence of mental health concerns in early adolescence. Such education may have shifted beliefs about seeking services. Thus, it is possible that these aspects of the youth development program contributed to increases in help-seeking intentions.

Generally, although this youth development program affected positive change in help-seeking intentions for participating families, this change could not be specifically ascribed to all

of the expected factors tested in the present model. Therefore, as is often the case in research, this finding suggests there were some areas of this study that could be improved.

Limitations

As in all projects, there are some limitations that should be noted. For one, the time period of this intervention for follow-up, although longitudinal, was not very lengthy. Six weeks from the beginning to end of camp is a brief window for even a powerful intervention to effect change. However, considering that results were able to show that help-seeking intentions increased during this short time suggests that even pre-/post-program data collection can capture a portion of the change. Thus, this project, although brief in its longitudinality, supports continuing to assess for how program participation can shape future orientation to seeking help.

Additionally, the size of the sample in this project was somewhat small (N = 124 youth, N = 135 caregivers) and the data set had significant missing data points (see Table 5). However, modern data analysis techniques were used that compensated for missing data. Furthermore, this sample size is similar to or greater than what has historically been obtained in community-based youth development program evaluations (e.g., N = 102 in Kreider & Raghupathy, 2010; N = 85 in Spoth, Guyll, Chao, & Molgaard, 2003).

Another issue of concern is that measuring intentions may not be the best way to capture a program's influence on behavior change because intentions are separate from behavior. Behaviors and intentions occur individually and may be affected by additional intervening variables. Despite this critique, the theory of planned behavior has long been supported in the literature (Ajzen, 2002). Interventions based on the theory of planned behavior have shown that behavioral intentions are highly correlated with and predictive of actual behaviors (Wilson et al., 2008). Furthermore, assessing intentions promotes easier data collection and data-based decision

making for community programs. Assessing behavioral intentions allows community programs to know in the short-term if their program has made an impact on willingness to seek help without having to complete long-term follow up. Long-term follow up is generally not feasible for community organizations as there are likely not additional resources for time, data management and retention efforts in many service-oriented organizations.

Future Directions and Policy Implications

Future evaluations of youth development programs would do well to assess for other variables that may explain how or why families would be persuaded to view service utilization favorably or even as a potential resource after the program ends. Factors such as existing stigma towards seeking mental health help, depth of previous experience with psychosocial support programs, expectations, attitudes, and perceived social norms about seeking mental-health help seem to be logical next steps for program evaluations, based on the results of this study. To complete such next steps, longitudinal projects that specifically assess parent and youth stigmatizing beliefs related to mental health issues, both before and after program participation, in addition to help-seeking intentions, may help answer these questions. It would also be beneficial (although challenging for a community agency such as the partner in this project) to employ long-term follow up methodology to demonstrate (a) what percentage of these youth need additional mental health support in the future and (b) what percentage of these families actually sought mental health support. Such methods would help further link help-seeking intentions with actual help-seeking actions.

With respect to broad-reaching implications, this study highlights the importance of completing program evaluations. This project shows that making data-based decisions in community-based youth development programs, even if research per se is not the organization's

stated purpose, can lead to successful programming. Although many programs do not sufficiently evaluate their outcomes (Roberts & Steele, 2005), the current study suggests that conducting data-driven analysis and program improvement can support program development and meeting an organization's stated goals, and also produce opportunities to further explore areas of important scientific inquiry. Furthermore, this project is highly consistent with the Applied Developmental Science principle of "outreach scholarship" (Lerner et al., 2005). This principle suggests that academically-oriented professionals should take ownership of building relationships with community organizations to collect data in order to generally improve the state of prevention and psychosocial programing for youth in this country. Consequently, the research and service provision model illustrated in this study may serve as an example for continuing progress in this area.

Although longitudinal data collection processes remain the highest standard of research to support causality, the results obtained in this study suggest that community-based youth development programs can still provide evidence of affecting future behaviors within a relatively short-term assessment. Developers of youth development programs would do well to broaden their perspectives on what counts as "success," such that shaping future behavioral intentions to meet psychosocial needs are considered as important as maintaining the absence of risky behaviors such programs seek to prevent.

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Appendix 1. Parent Demographic and Service Utilization Measure

Parent Demographic Questionnaire

1. I am a :
   a. Female
   b. Male

2. I am _____ years old.

3. My race/ethnicity is (Select one or more responses):
   a. Asian
   b. American Indian or Alaska Native
   c. Black or African American
   d. Hispanic or Latin
   e. Native Hawaiian or other Pacific Islander
   f. White or Caucasian
   g. Other_____

4. I am this child's:
   a. Parent
   b. Grandparent
   c. Step-parent
   d. Aunt or Uncle
   f. Other_____

5. The highest level of schooling I've completed is:
   a. Some high school
   b. High school graduate or GED
   c. Trade school or community college graduate
   e. Some college
   f. College graduate
   g. Graduate or professional school

6. My child was in the _____ grade last year:

7. In school, my child's grades are:
   a. Mostly A's
   b. Mostly B's
   c. Mostly C's
   d. Mostly D's
   e. Mostly F's

8. I would like my child's grades to be:
   a. Mostly A's
   b. Mostly B's
   c. Mostly C's
   d. Mostly D's
   e. Mostly F's

9. My child's weight is _____lbs.

10. My child's height is ____ft. ____in.

11. The number of people is my family is _____.

12. My family's yearly income is:

a. $10,000 or less
b. $10,000-$20,000
c. $20,000-$30,000
d. $30,000-$40,000
e. $40,000-$50,000
f. $50,000-$60,000
g. $60,000 or more

13. On a scale from 1-10 (1 being not at all stressed to 10 being extremely stressed), what is your given level of stress on an average day? Please circle the answer using the scale below.

1	2	3	4	5	6	7	8	9	10
(Not Stressed)									(Extreme Stress)

14. On a scale from 1-10 (1 being not at all stressed to 10 being extremely stressed), how stressful is parenting for you? Please circle the answer using the scale below.

1	2	3	4	5	6	7	8	9	10
(Not Stressed)									(Extreme Stress)

15. In a given week, how often do you reach the stress level indicated in Question #14? (See previous question's answer.)

a. Always
b. Often
c. Sometimes
d. Rarely
e. Never

16. Do you receive any of the following benefits? (Check all that apply)

a. Social Security Benefits
b. Survivor Benefits
c. Food Stamps
d. WIC (Women, Infants, and Children Program)
e. TANF (Temporary Assistance to Needy Families)
f. Child Support
g. Other (Please describe): _____

17. Number of times your family has moved in the past year: _____

18. Current living situation:

a. House (your name is on the lease)
b. Apartment (your name is on the lease)
c. Extended family
d. Shelter
e. We stay from place to place
f. Other (Please describe): _____

19. How many people live in your home right now? _____
How many are children? _____

20. What local services/resources do you/your children receive?

a. Faith-based (for example, programs or events through church, synagogue, etc.)
b. Services through community organization/center (for example, Salvation Army, YMCA)
c. Services or check-ups at community health clinic (including Planned Parenthood)
d. Hospital
e. Mental health services
f. Case management
g. Substance abuse programs
h. Disability services
i. Housing support or assistance (for example, help finding affordable housing)
j. Residential services (e.g., homeless shelter, safe house, youth shelter)
k. Assistance with clothes, food, and other items (for example soup kitchen)
l. Assistance with finances (for example, rent, bills)
m. Public transportation
n. Library
o. Museums or other local attractions
p. Movie theaters
q. Newspaper, radio, or other media-related resources
r. Parks / Recreation areas
s. Neighborhood parent support groups
t. Parent activity programs
u. Head Start / Early Head Start
v. Child care
w. Before- / After-school programs
x. Tutoring programs
y. Mentoring programs
z. Other (Please list): _____

Appendix 2. Child Demographic Measure

Child Demographic Information

1. l am a:	a. Female b. Male
2. I am _____ years old.	
3. My race/ethnicity is: (Select one or more responses)	a. Asian b. American Indian or Alaska Native c. Black or African American d. Hispanic or Latin e. Native Hawaiian or other Pacific Islander g. White or Caucasian f. Other _____
4. Have you been to AileyCamp before?	a. Yes, in _____ (what year?) b. No
5. I was in the grade last year:	a. 5th grade or lower b. 6th grade c. 7th grade d. 8th grade e. 9th grade f. 10th or higher
6. In school, my grades are:	a. Mostly A's b. Mostly B's c. Mostly C's d. Mostly D's e. Mostly F's
7. I would like my grades to be:	a. Mostly A's b. Mostly B's c. Mostly C's d. Mostly D's e. Mostly F's

8. I would describe my health as:	a. Excellent b. Very good c. Good d. Fair e. Poor

Appendix 3. Parent Satisfaction Measure

AileyCamp Parent Satisfaction Questionnaire

Directions: Please answer the questions below by circling the number that goes with the statement that describes how you feel about AileyCamp.

	Really False	False	True	Really True
1) I feel like AileyCamp has helped my child to become healthier and more fit.	1	2	3	4
2) My child has more flexibility now than before beginning AileyCamp.	1	2	3	4
3) The people at AileyCamp treated my family and my child with respect.	1	2	3	4
4) I am glad my child went to AileyCamp.	1	2	3	4
5) I would recommend AileyCamp to other parents.	1	2	3	4
6) I feel like my child is now better able to handle conflict situations than before beginning AileyCamp.	1	2	3	4
7) The people at AileyCamp were understanding and accepting of my family's needs.	1	2	3	4
8) I feel like AileyCamp has taught my child to be more responsible.	1	2	3	4
9) I trust the people at AileyCamp.	1	2	3	4

Appendix 4. Child Satisfaction Measure

AileyCamper Satisfaction Questionnaire

Directions: Please answer the questions below by circling the number that goes with the statement that describes how you feel about AileyCamp.

	Really False	False	True	Really True
1) I feel like AileyCamp has helped me to become healthier and more fit.	1	2	3	4
2) I have more flexibility now than I did before beginning AileyCamp.	1	2	3	4
3) The people at AileyCamp treated me with more respect than other adults in my life.	1	2	3	4
4) I really liked my experience at AileyCamp.	1	2	3	4
5) I would recommend AileyCamp to my friends or other kids.	1	2	3	4
6) I feel like I am better able to handle conflict situations.	1	2	3	4
7) The people at AileyCamp understood and accepted me.	1	2	3	4
8) I feel that AileyCamp has helped me be more confident in myself.	1	2	3	4
9) I trust the people at AileyCamp.	1	2	3	4

Appendix 5. Family Support Scale Measure

Listed below are people and groups that are often helpful to members of a family raising a child. This questionnaire asks you to indicate how helpful each source is to ***your family***.

Please ***circle*** the response that best describes how helpful the sources have been to your family during the past ***3-6 months***. If a source of help has not been available to your family during this period of time, circle the NA (Not Available) response.

How helpful has each of the following been to you in terms of raising your child(ren):	Not Available	Not at all Helpful	Seldom Helpful	Sometimes Helpful	Usually Helpful	Almost Always Helpful
1. My parents	NA	1	2	3	4	5
2. My spouse or partner's parents	NA	1	2	3	4	5
3. My relatives or family	NA	1	2	3	4	5
4. My spouse or partner's relatives or family	NA	1	2	3	4	5
5. Spouse or partner	NA	1	2	3	4	5
6. My friends	NA	1	2	3	4	5
7. My spouse or partner's friends	NA	1	2	3	4	5
8. My own children	NA	1	2	3	4	5
9. Other parents	NA	1	2	3	4	5
10. Co-workers	NA	1	2	3	4	5
11 Parent groups	NA	1	2	3	4	5
12. Social groups or clubs	NA	1	2	3	4	5
13 Church members or minister	NA	1	2	3	4	5
14. My family or child's physician	NA	1	2	3	4	5
15 Childhood intervention programs (Boys and Girls club, YMCA, etc.)	NA	1	2	3	4	5
16. School	NA	1	2	3	4	5

17 Professional helpers (social workers, therapists, teachers, etc.)	NA	1	2	3	4	5
18. Professional agencies (public health, social services, mental health, etc.)	NA	1	2	3	4	5
19 AileyCamp staff	NA	1	2	3	4	5
20. Other_____	NA	1	2	3	4	5

Appendix 6. General Help Seeking Questionnaire Measure

General Help Seeking Questionnaire

1. If **your child** was having a **personal/emotional** problem, how likely is it that you would seek help for them from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely **3 = Unlikely** **5 = Likely** **7 = Extremely Likely**

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, other)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
b. Friend (not related to you)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
c. My parents/my partner's parents	**1**	**2**	**3**	**4**	**5**	**6**	**7**
d. Other relative/family member	**1**	**2**	**3**	**4**	**5**	**6**	**7**
e. Mental health professional (e.g., psychologist, social worker, counselor)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
f. Professional agencies (e.g., public health, social services, school system)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
g. My family or child's physician	**1**	**2**	**3**	**4**	**5**	**6**	**7**
h. Minister, religious leader, or church members i.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
j. I would not seek help from anyone k.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
l. I would seek help from another not listed above (Please list in the space provided; If no, leave blank): _____	**1**	**2**	**3**	**4**	**5**	**6**	**7**

2. If **your child** was having a **behavior/drug use** problem, how likely is it that you would seek help for them from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely **3 = Unlikely** **5 = Likely** **7 = Extremely Likely**

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, other)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
b. Friend (not related to you)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
c. My parents/my partner's parents	**1**	**2**	**3**	**4**	**5**	**6**	**7**
d. Other relative/family member	**1**	**2**	**3**	**4**	**5**	**6**	**7**
e. Mental health professional (e.g., psychologist, social worker, counselor)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
f. Professional agencies (e.g., public health, social services, school system)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
g. My family or child's physician	**1**	**2**	**3**	**4**	**5**	**6**	**7**
h. Minister, religious leader, or church members i.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
j. I would not seek help from anyone k.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
l. I would seek help from another not listed above (Please list in the space provided; If no, leave blank): _____	**1**	**2**	**3**	**4**	**5**	**6**	**7**

3. If **<u>you</u>** were having a **<u>personal/emotional</u>** problem, how likely is it that you would seek help from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely 3 = Unlikely 5 = Likely 7 = Extremely Likely

a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, other)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
b. Friend (not related to you)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
c. My parents/my partner's parents	**1**	**2**	**3**	**4**	**5**	**6**	**7**
d. Other relative/family member	**1**	**2**	**3**	**4**	**5**	**6**	**7**
e. Mental health professional (e.g., psychologist, social worker, counselor)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
f. Professional agencies (e.g., public health, social services, school system)	**1**	**2**	**3**	**4**	**5**	**6**	**7**
g. My family or child's physician	**1**	**2**	**3**	**4**	**5**	**6**	**7**
h. Minister, religious leader, or church members i.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
j. I would not seek help from anyone k.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
l. I would seek help from another not listed above (Please list in the space provided; If no, leave blank): _____	**1**	**2**	**3**	**4**	**5**	**6**	**7**